Dr. David & Ruth Lambert D.D.S
805 Grove St.
Lenoir City, TN 37774
865-458-9556

PARENTAL CONSENT FORM FOR DENTAL TREATMENT

Childs Full Name:______________________________

Date of Birth: _________________________________

Although every effort will be made to adhere to the proposed treatment plan, unforeseen circumstances or conditions may require a departure from the plan. If your are unable to remain in the dental office while your child is receiving dental treatment the following circumstances will apply:

I am leaving the treatment of my child to the doctor's judgment and experience. I understand that other treatment may need to be rendered by the doctor or within the routine hygiene care as followed by the American Dental Association. This includes the rendering of x-rays and fluoride. The doctor, hygienist and staff have permission to do whatever they feel necessary.

In the event the parent or guardian needs to be contacted, they can be reached at the following phone number:__________________

This consent is for the duration that the below named minor patient is undergoing treatment at our office as a parent of record. The termination of the consent is only granted in the event the below minor becomes 18 years of age or the parent or guardian revokes the consent in writing to Dr. David W. Lambert DDS .

Parent or Legal Guardian (Print):__________________________________

Parent or Legal Guardian(Signature):______________________________

Date:_________________